## **Sexual Assault Forensic Examination Reimbursement**

Idaho Crime Victims Compensation Program

CRIME INFORMATION	
Crime Type: Adult Sexual Assault	
VICTIM INFORMATION	
Victim's Name:	SSN:
Victim's Address:	City: State: Zip:
Victim's Date of Birth: / / Gender:   Male Female Phone #: ( )	
Legal Guardian:	
Relationship: Email Address:	
Address (if different from Victim):	
ADULT VICTIMS (check all that apply)	MINOR VICTIMS (check all that apply)
☐ Medicaid Policy #	☐ Medicaid Policy #
☐ Medicare Policy #	☐ Medicare Policy #
☐ VA Benefits Policy #	☐ Insurance:
•	Policy #
MEDICAL FACILITY INFORMATION	
Medical Facility where Examination was Completed:	
	City: State: Zip:
SANE Nurse:Phone	#: ( ) Anonymous Kit: $\square$ Yes $\square$ No
Patient should not be billed for Sexual Assault Exam. Required billing documentation listed on reverse side of form. Submit to:  Crime Victims Compensation Program P. O. Box 83720, Boise, Idaho 83720-0041 For Questions Call: (208) 334-6080 or (800) 950-2110	
LAW ENFORCEMENT INFORMATION	
Was a law enforcement report filed under the victim's name? ☐ Yes ☐ No	
If so, Law Enforcement Agency: Report #:  Name of Person Who Committed Crime (Optional):	
AUTHORIZATION TO RELEASE INFORMATION	
I authorize my billing information and Sexual Assault Examination medical records relating to this examination to be released to the Crime Victims Compensation Program for payment consideration and to the prosecutor's office for the purposes of securing restitution.	
XXX	
Signature of Victim or Legal Guardian (Parent/Legal Guardian if vi	ctim is a minor) Date